2002 transactions deadline is questionable—even unlikely.

Further evidence of the difficulty of meeting the October 16, 2002 deadline for transactions and code sets found in an October 11, 2001 letter signed by the National Governors Association, National Conference of State Legislatures, Council of State Governments, National Association of Counties, National League of Cities, and the U.S. Conference of Mayors which stated ''State and local governments will be unable to meet the requirements of HIPAA under the current implementation schedule. Regardless of whether other covered entities—such as hospitals, health plans, providers, and clearinghouse—except to be compliant with HIPAA under the current system, if state and local governments are not ready, HIPAA will not work.''

The bill on the floor today represents a compromise. The bill does not contain all of the provisions I would like. It is, however, an improvement over its original form, which contained an onerous user fee on Medicare providers, an idea that has been rejected by the House of Representatives time and time again. In addition, the compliance plans that covered entities will have to submit—something that will get entities to focus on how to come into compliance—will be less burdensome under the new amended bill. I still have concerns about the bill's effect on small providers, but believe that the exceptions we have included are sufficient to not punish small physician practices.

Mr. Speaker, I want to thank Mr. HOBSON, Mr. SAWYER, Chairman TAUZIN, and Chairman THOMAS for their work on this issue.

Mr. DINGELL. Mr. Speaker, H.R. 3323, the ''Administrative Simplification Compliance Act'' is a responsible compromise. Congressman HOBSON and SAWYER have addressed the concerns of the health care industry while maintaining the integrity of the administrative simplification requirements. H.R. 3323 also reflects the bipartisan input of the committees of jurisdiction, the Committee on Energy and Commerce and the Committee on Ways and Means.

H.R. 3323 delays the implementation of the administrative simplification requirements in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by one year. It ensures, however, that those sectors of the health care industry that take advantage of this delay are using the extra year to ready themselves for compliance.

Most importantly, the bill ensures that the one-year delay of administrative simplification does not touch the implementation of the health information privacy requirements in HIPAA, which will go into effect as scheduled.

H.R. 3323 also requires that Medicare claims be submitted electronically, with reasonable exceptions. The Medicare program has paved the way in moving from paper-based claims processing to electronic processing, and this requirement will help Medicare run more smoothly.

Ultimately, the administration simplification requirements in HIPAA will make our health system more efficient. These requirements will result in billions of dollars in savings, thus freeing up more funds to focus on expanding health care coverage and promoting higher quality care. H.R. 3323 reaffirms the importance of these requirements while giving additional time to prepare for their implementation. I ask my colleagues to join me in support of this bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentleman from Louisiana (Mr. TAUZIN) that the House suspend the rules and pass the bill, H.R. 3323, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mrs. JOHNSON of Connecticut. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001

Mrs. JOHNSON of Connecticut. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3391) to amend title XVIII of the Social Security Act to provide regulatory relief and contracting flexibility under the Medicare Program.

The Clerk read as follows:

H.R. 3391

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Regulatory and Contracting Reform Act of 2001''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS AND CONSTRUCTION.

(a) FINDINGS.—Congress finds the following:

(1) The overwhelming majority of providers of services and suppliers in the United States are law-abiding persons who provide important health care services to patients each day.

(2) The Secretary of Health and Human Services should work to streamline paperwork requirements under the medicare program and communicate clearer instructions to providers of services and suppliers so that they may spend more time caring for patients.

(b) CONSTRUCTION.—Nothing in this Act shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

SEC. 3. DEFINITIONS.

(a) USE OF TERM SUPPLIER IN MEDICARE.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

''Supplier

''(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.''.

(b) OTHER TERMS USED IN ACT.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

TITLE I—REGULATORY REFORM

SEC. 101. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1) Subject to paragraph (2), the Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month.

''(2) The Secretary may issue a proposed or final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

''(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

''(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.

''(3) The Secretary shall coordinate issuance of new regulations described in paragraph (1) relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.''.

(2) GAO REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act be promulgated on a quarterly basis rather than on a monthly basis.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

''(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

''(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

''(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

''(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 102. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 101(a), is amended by adding at the end the following new subsection:

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

''(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

''(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

''(2)(A) If—

''(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

''(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

''(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

''(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 103. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than January 1, 2003.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 2(a), is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

TITLE II—CONTRACTING REFORM

SEC. 201. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

''(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

''(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary

may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

''(4) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,''; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection

(a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2003, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2008.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2002, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2006, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 202. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 201(a)(1), is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

''(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

''(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

''(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

''(C) REPORTS ON EVALUATIONS.—

''(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

''(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Servvices shall submit to Congress annual reports on the results of such evaluations.''.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

TITLE III—EDUCATION AND OUTREACH

SEC. 301. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2002, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 201(a)(1) and as amended by section 202(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND

OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2002, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f)(1) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2002, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 201(a)(1) and as amended by section 202(a) and subsection (b), is further amended by adding at the end the following new subsection:

''(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.''.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2002.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

''(b) ENHANCED EDUCATION AND TRAINING.—

''(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2003 and 2004 and such sums as may be necessary for succeeding fiscal years.

''(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

''(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

''(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 302. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under

medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term ''small providers of services or suppliers'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2003, $1,000,000, and

(2) for fiscal year 2004, $6,000,000.

SEC. 303. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1807. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

''(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

''(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.''.

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2002 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to

benefits under part A or enrolled under part B, or both, through the toll-free number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 304. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

TITLE IV—APPEALS AND RECOVERY

SEC. 401. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2002, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than April 1, 2003, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2003, and not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2003 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking ''of the Social Security Administration''.

SEC. 402. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision'';

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking ''PROCEEDING'' and all that follows through ''DETERMINATION'' and inserting ''DETERMINATIONS AND RECONSIDERATIONS''; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

(3) by adding at the end the following new paragraph:

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review panel—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund

and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

''(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2002.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2003 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 403. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 402(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall include—

''(A) the specific reasons for the determination, including—

''(i) upon request, the provision of the policy, manual, or regulation used in making the determination; and

''(ii) as appropriate in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination;

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

The written notice on a redetermination shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing, ''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision, ''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

(B) by adding at the end the following new subparagraph:

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(B) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

''(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

''(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(4) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 404. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 201(a)(1) and as amended by sections 202(b), 301(b)(1), and 301(c)(1), is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

''(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

''(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

''(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

''(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

''(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

''(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 405. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) HARDSHIP.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

''(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

''(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

''(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

''(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed

as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

''(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services or supplier—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

''(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(7) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

''(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

''(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

''(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 406. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: ''; ENROLLMENT PROCESSES''; and

(2) by adding at the end the following new subsection:

''(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) ENROLLMENT PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

''(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

''(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

''(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2002.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 407. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

SEC. 408. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 403(d)(2)(B), is further amended by adding at the end the following new subsection:

''(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

''(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

''(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

''(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

''(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

''(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

''(3) REQUEST FOR PRIOR DETERMINATION.—

''(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

''(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

''(4) RESPONSE TO REQUEST.—

''(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

''(i) the item or service is so covered;

''(ii) the item or service is not so covered; or

''(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

''(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

''(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

''(5) EFFECT OF DETERMINATIONS.—

''(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

''(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

''(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

''(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

''(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

''(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

''(6) LIMITATION ON FURTHER REVIEW.—

''(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

''(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

''(i) decides not to seek a prior determination under this subsection with respect to items or services; or

''(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii)), from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

''(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (4)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

TITLE V—MISCELLANEOUS PROVISIONS

SEC. 501. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2003, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2003, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 502. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) IMPROVED COORDINATION BETWEEN FDA AND CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

(1) IN GENERAL.—Upon request by an applicant and to the extent feasible (as determined by the Secretary), the Secretary shall, in the case of a class III medical device that is subject to premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act, ensure the sharing of appropriate information from the review for application for premarket approval conducted by the Food and Drug Administration for coverage decisions under title XVIII of the Social Security Act.

(2) PUBLICATION OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to appropriate Committees of Congress a report that contains the plan for improving such coordination and for shortening the time lag between the premarket approval by the Food and Drug Administration and coding and coverage decisions by the Centers for Medicare & Medicaid Services.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the criteria for coverage of a medical device under title XVIII of the Social Security Act nor premarket approval by the Food and Drug Administration and nothing in this subsection shall be construed to increase premarket approval application requirements under the Federal Food, Drug, and Cosmetic Act.

(b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 301(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians

and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2002, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) IOM STUDY ON LOCAL COVERAGE DETERMINATIONS.—

(1) STUDY.—The Secretary shall enter into an arrangement with the Institute of Medicine of the National Academy of Sciences under which the Institute shall conduct a study on local coverage determinations (including the application of local medical review policies) under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(A) the consistency of the definitions used in such determinations;

(B) the types of evidence on which such determinations are based, including medical and scientific evidence;

(C) the advantages and disadvantages of local coverage decisionmaking, including the flexibility it offers for ensuring timely patient access to new medical technology for which data are still be collected;

(D) the manner in which the local coverage determination process is used to develop data needed for a national coverage determination, including the need for collection of such data within a protocol and informed consent by individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both; and

(E) the advantages and disadvantages of maintaining local medicare contractor advisory committees that can advise on local coverage decisions based on an open, collaborative public process.

(2) REPORT.—Such arrangement shall provide that the Institute shall submit to the Secretary a report on such study by not later than 3 years after the date of the enactment of this Act. The Secretary shall promptly transmit a copy of such report to Congress.

(e) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2003 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

SEC. 503. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 504. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2002.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the report on the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 505. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 506. AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following new subparagraph:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 507. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

(B) by adding at the end of subsection (b) the following new paragraph:

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2002.

SEC. 508. ONE-YEAR DELAY IN LOCK IN PROCEDURES FOR MEDICARE+CHOICE PLANS; CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD FOR 2002.

(a) LOCK-IN DELAY.—Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended—

(1) in paragraph (2)(A), by striking ''THROUGH 2001'' and ''and 2001'' and inserting ''THROUGH 2002'' and ''2001, and 2002'', respectively;

(2) in paragraph (2)(B), by striking ''DURING 2002'' and inserting ''DURING 2003'';

(3) in paragraphs (2)(B)(i) and (2)(C)(i), by striking ''2002'' and inserting ''2003'' each place it appears;

(4) in paragraph (2)(D), by striking ''2001'' and inserting ''2002''; and

(5) in paragraph (4), by striking ''2002'' and inserting ''2003'' each place it appears.

(b) CHANGE IN DEADLINES AND ELECTION PERIOD.—

(1) IN GENERAL.—Notwithstanding any other provision of law—

(A) the deadline for submittal of information under section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) for 2002 is changed from July 1, 2002, to the third Monday in September of 2002; and

(B) the annual, coordinated election period under section 1851(e)(3)(B) of such Act (42 U.S.C. 1395w–21(e)(3)(B)) with respect to 2003 shall be the period beginning on November 15, 2002, and ending on December 31, 2002.

(2) GAO STUDY ON IMPACT OF CHANGE ON BENEFICIARIES AND PLANS.—The Comptroller General of the United States shall conduct a review of the Medicare+Choice open enrollment process that occurred during 2001, including the offering of Medicare+Choice plans for 2002. By not later than May 31, 2002, the Comptroller General shall submit a report to Congress and the Secretary on such review. Such report shall include the following:

(A) An analysis of the effect of allowing additional time for the submittal of adjusted community rates and other data on the extent of participation of Medicare+Choice organizations and on the benefits offered under Medicare+Choice plans.

(B) An evaluation of the plan-specific information provided to beneficiaries, the timeliness of the receipt of such information, the adequacy of the duration of the open enrollment period, and relevant operational issues that arise as a result of the timing and duration of the open enrollment period, including any problems related to the provision services immediately following enrollment.

(C) The results of surveys of beneficiaries and Medicare+Choice organizations.

(D) Such recommendations regarding the appropriateness of the changes provided under paragraph (1) as the Comptroller General finds appropriate.

SEC. 509. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review —policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause –(I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' –and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 510. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 511. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 512. MISCELLANEOUS REPORTS, STUDIES, AND PUBLICATION REQUIREMENTS.

(a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

(1) SUSTAINABLE GROWTH RATE AND UPDATES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) PHYSICIAN COMPENSATION GENERALLY.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—The Secretary shall submit to Congress as expeditiously as practicable the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from California (Mr. STARK) each will control 20 minutes.

The Chair recognizes the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 10 minutes to the gentleman from Louisiana (Mr. TAUZIN), and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Connecticut?

There was no objection.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, Secretary Thompson said about Medicare, ''Complexity is over the system, criminalizing honest mistakes, and driving doctors, nurses, and other health care professionals out of the program.''

I agree.

Medicare and Medicaid are governed by 132,000 pages of regulations. That is 3 times the IRS Code and its regulations and the result is exactly as the Secretary described.

Memorial Hospital in Gonzales, Texas has 33 beds and 20 billing staff. Northwestern Memorial Hospital in Chicago just hired 26 new full-time employees to meet new regulatory requirements.

At a time when we need Medicare dollars for more nursing care, prescription drugs, annual physicals, and new systems to help seniors manage multiple chronic illnesses, we cannot in good conscience ignore the costly administrative burdens and the multitude of injustices being heaped on Medicare doctors, hospitals, home health care providers, nursing homes, and other providers by a literal explosion of complex law, regulation directives, and paperwork.

To address what I consider to be a crisis endangering the ability of small providers and many doctors to continue to serve our Nation's seniors, last January my subcommittee began taking a hard look at provider complaints. Today we bring to you a bipartisan bill to address the severe problems that have developed in Medicare.

The bill before us does many radical things. It disciplines the regulatory process so regulations will be issued through a predictable and timely process, with provider input before proposed regulations are made public.

Another radical thing it does, it stops, it prohibits government from imposing regulations retroactively. There will be no more changing the rules of the game and then punishing providers for noncompliance. It prohibits, read that ''stops,'' government from imposing sanctions and demanding repayment if they provided care to seniors in compliance with written guidance from the government. It speeds up the process Medicare uses to set payments for new diagnostic and treatment technologies by creating a Council of Technology and Innovation. It requires a simple process to correct technical error, relieving our caregivers of all the paperwork and severe cash flow problems that result from the laborious appeals process, a killer of small providers.

Radically, we require through this bill that the people who process payments for Medicare services answer questions accurately. GAO found that these contractors answered only 15 percent of routine questions accurately, and, worse yet, 32 percent of provider questions were answered completely inaccurately.

By setting performance standards in competitive contracting, Medicare can assure better-quality provider support services.

Under this bill, doctors get fairer treatment when audited for billing inaccuracy. They will get explanations, the right to discuss coding differences, and written explanations when differences remain. This should stop the arbitrary decisions that result in tens of thousands of dollars of unjust fines.

When a physician who is responsible for running the Medicare program tells me she cannot tell the difference between a comprehensive physical and a detailed physical, two entirely different levels of care for billing purposes, should we be surprised that doctors who make coding errors are frustrated and angered by Medicare's arbitrary, confrontational audits by nonmedical people and its complex, irrational documentation requirements?

□ 1700

I am proud that this is a bipartisan bill. It has been developed with the study and input of every member of the Ways and Means Subcommittee on Health, and then the follow-on input of the Committee on Energy and Commerce, Republicans and Democrats, as well as the administration and the Inspector General.

I want to especially thank John McManus, Jennifer Baxendell, Deborah

Williams, Joel White, Cybele Bjorklund and Carl Taylor, our Republican and Democratic staff members of the Committee on Ways and Means, because this has been an incredibly time-consuming, work-intensive bill. Without their endless attention to detail and thoughtful, sound judgments, it would not be before us today.

Please support H.R. 3391. It is a giant step toward a stronger Medicare program.

THANK YOUS ON H.R. 3391

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DEPT. OF HEALTH AND HUMAN SERVICES

Staff.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I ask unanimous consent that at the conclusion of 10 minutes of my time that 10 minutes be yielded to the gentleman from Ohio (Mr. BROWN) for the purposes of control.

The SPEAKER pro tempore (Mr. CULBERSON). Is there objection to the request of the gentleman from California?

There was no objection.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

The bill we are moving today embodies basically the way Congress used to work, with the majority and minority working together to enact improvements to the Medicare program. On this bill, the Medicare Regulatory and Contracting Reform Act, both sides have worked closely with the administration, with providers, consumers groups and others. It has been a bipartisan, consultative process as it should be.

In addition, Mr. Speaker, I think it is important to acknowledge the outstanding leadership and hard work of the gentlewoman from Nevada (Ms. BERKLEY). She brought this matter to the attention of Congress and has shepherded it along the way and has been an invaluable help in seeing this legislation be completed.

The legislation contains important beneficiary provisions which I think are important to emphasize. We have established a beneficiary ombudsman program that will provide a voice for beneficiaries within the Centers for Medicare and Medicaid Services, now CMS, I still want to call it HCFA, but will enable that agency to better respond to and anticipate beneficiary needs. As every Member knows, Members must now help Medicare beneficiaries with their casework because no office really exists within CMS to help the beneficiaries.

We have also established a single national toll free telephone number, 1–800–MEDICARE, I hope it answers, for the beneficiaries to call with their questions; and this single telephone number will replace the many pages of telephone numbers that beneficiaries now must sort through in the Medicare handbook to find the correct place to call with their questions.

I am particularly pleased that a demonstration program will place Medicare staff in Social Security field offices to answer beneficiary questions and provide assistance on Medicare issues. Beneficiaries are accustomed to going to Social Security offices, as indeed are the caseworkers in our local offices, for help and assistance in these programs. This will help by having Medicare assistance for them in these same offices.

I would also like to suggest accolades for the gentleman from Pennsylvania (Mr. ENGLISH), who has worked with me on a bill to protect nurses and other health care workers from needle stick injuries by requiring the use of safe needle technology in public hospitals, as well as has been required by those hospitals under OSHA supervision. We have been working on this issue for years, and we have made significant progress; and this legislation completes those efforts, and this provision in the bill will save lives. It is an important component of the bill.

Importantly, this bill delays for a year the requirement in law that would begin in 2002 to lock beneficiaries into the Medicare+Choice plans, and under this legislation beneficiaries would continue to be able to enroll in and disenroll from these plans throughout the year. I would strongly prefer to repeal the lock-in altogether, but I believe a 1-year delay is a good start.

Finally, the bill takes long overdue steps to fundamentally reform Medicare's contracting system. We have worked on this for years. I am confident under this new system we can get a better deal for our government and still maintain quality service and performance goals for the beneficiary.

This will place additional administrative burdens on CMS; and as we discussed earlier today with the gentleman from Ohio (Mr. HOBSON) and others, we will continue to see that Labor HHS appropriation bills provide modest increases in administrative resources for CMS to complete this work.

I guess that said, Mr. Speaker, I have to add that I think it is somewhat disgraceful that this ends up being our really only Medicare legislation this year. We started the 107th Congress with a record budget surplus and the ability to easily enact and pay for comprehensive, affordable prescription drug coverage and other significant improvements through all Medicare beneficiaries, in addition to funding other key national priorities in education and other social areas.

The surplus, instead, was squandered on excessive tax breaks for the wealthy, and it is now clear that the Bush recession that began last spring and the Republican tax package have sealed the deal. Our legislative record at the end of the first session of the 107th Congress is a tribute to misplaced priorities.

I look forward to changing that and working with my colleagues as we have on this bill on the Subcommittee on Health to see if in the next session of Congress we can reverse this course and improve the Medicare system as it has long been set aside from doing.

Mr. Speaker, I reserve the balance of my time.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is my privilege to yield 1½ minutes to the gentlewoman from Washington (Ms. DUNN), a hardworking member of our subcommittee.

Ms. DUNN. Mr. Speaker, I rise in support of this bill to provide regulatory relief to doctors throughout the Nation. I want to thank the gentleman from California (Mr. THOMAS) for being involved in developing this legislation; but I want to give special kudos to the gentlewoman from Connecticut (Mrs. JOHNSON), the subcommittee chairman, and the gentleman from California (Mr. STARK), her ranking member, because they worked together. This is bipartisan and we are very pleased with the result of our work. It will cost nothing, but it does true regulatory reform.

I also want to thank my colleagues, the gentleman from Maryland (Mr. EHRLICH) and the gentleman from Washington (Mr. MCDERMOTT), for working with me to ensure that in this bill our seniors have access to the latest clinical laboratory tests.

I am very pleased that this regulatory relief bill creates a transparent, timely and public process at CMS to evaluate and to incorporate new technologies into the Medicare program. This is a critical step in ensuring that doctors have every tool available to assist our seniors.

Medical innovations are moving too fast to wait for Medicare's coverage and payments. This is especially true for new laboratory tests, a field that has been rapidly advancing in innovations exponentially.

The quality of our health care system here in the United States depends on our ability to prevent, diagnose, and treat illnesses and diseases. Support this legislation so that our Nation's seniors will be able to access breakthrough tests that can help save their lives.

Mr. STARK. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Nevada (Ms. BERKLEY), who is one of the originators of this legislation.

Ms. BERKLEY. Mr. Speaker, I rise today in strong support of H.R. 3391, to

provide long-awaited Medicare regulatory relief to health care providers. I would like to particularly thank my colleagues who have worked so hard to make this piece of legislation a reality, the gentlewoman from Connecticut (Mrs. JOHNSON); the gentleman from California (Mr. STARK), especially for his very generous praise, I appreciate that; the gentleman from Ohio (Mr. BROWN); the gentleman from Florida (Mr. BILIRAKIS); the gentleman from New York (Mr. RANGEL); the gentleman from California (Mr. THOMAS); the gentleman from Louisiana (Mr. TAUZIN); and the gentleman from Michigan (Mr. DINGELL) for their hard work on this legislation. I would especially like to thank the gentleman from Pennsylvania (Mr. TOOMEY) for his leadership on this issue.

I became involved with this legislation when doctor after doctor in the Las Vegas area came to me with horror stories of how they had been treated by HCFA and how it had inhibited their ability to care for their patients. The cornerstone of health care in this country is the doctor-patient relationship, and many of us have fought consistently to maintain the integrity of this fundamental and very personal relationship.

Over the years, excessive paperwork and overburdensome government regulation have interfered with that relationship. This legislation will help cut red tape and bureaucratic excesses so doctors can spend more time with their patients and less time on paperwork.

Reform is important to the doctors, important to our seniors, and vital to the health of Medicare. While this bill, as the gentleman from California (Mr. STARK) says, does not include everything I had hoped for, it is a very significant step in the right direction. I am proud that my name is associated with this bill, and I urge all of my colleagues to support it.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

I would like to thank the gentlewoman from Nevada (Ms. BERKLEY) and the gentleman from Pennsylvania (Mr. TOOMEY), who is going to speak later, for their hard work on behalf of physicians, most of which is reflected in this legislation.

Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. GILMAN).

(Mr. GILMAN asked and was given permission to revise and extend his remarks.)

Mr. GILMAN. Mr. Speaker, I am pleased to rise in support of H.R. 3391. This legislation makes extensive changes and modifications in the regulatory and contracting systems within Medicare, and I commend the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from California (Mr. STARK) for their work on this measure.

Along with many of our colleagues, I have heard in recent years that increasing drumbeat of criticism, from health care providers and patients in my own district, over a cumbersome Medicare system that was slow to adapt to rapid changes in health care, cumbersome in its management of existing benefits, and required far too much time spent in processing paperwork for claims reimbursements.

Moreover, there is also a widespread perception that the Centers for Medicare and Medicaid Services, formerly known as HCFA, has in the past issued new regulations in an arbitrary and capricious manner, with little regard for the interests and situations of those health care providers who would be impacted by a regulatory change. The fact that many of these changes came without sufficient accompanying explanations further exacerbated problems for providers and patients who often have difficulty divining the arcane and often confusing world of Medicare regulations.

There is also the issue of the Medicare contracting program which, in this age of open government, remains a closed system. This has fostered inefficiency and prevented the Medicare contracting program from keeping up with rapid developments in the delivery of health care in the private sector.

H.R. 3391 is a bipartisan solution to address these problems and to serve as the first step in modernizing overhaul of the Medicare system, which streamlines the regulatory process, reforms the contracting system to make it more open and accountable, expanding outreach and education to better inform both providers and patients of their rights and responsibilities, and makes important improvements to the appeals and recovery process.

Mr. Speaker, Medicare, along with the Social Security system, represents the most popular and successful program for seniors ever enacted. This bill will ensure the continued success of the system by making it easier for Medicare health care providers to operate within the system, as well as to offer relief through the reduction of paperwork burdens.

This measure will both reform the Medicare system and improve confidence in its future on the part of both providers and patients. Accordingly, I urge my colleagues to fully join in supporting this measure.

Mr. STARK. Mr. Speaker, I am pleased to yield 2½ minutes to the gentlewoman from Florida (Mrs. THURMAN), who has worked diligently on this legislation in behalf of all the seniors, most of whom I think reside in her district in Florida, but for all of the rest of us seniors who do not.

Mrs. THURMAN. Mr. Speaker, I want to thank the gentleman from California (Mr. STARK) for yielding me this time and those nice remarks, but I also want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN). Without their diligence and all of the committees working together, this piece of legislation would not have been brought forward to this floor.

People sometimes do not realize how complicated Medicare can be at times; and when one is trying to balance beneficiaries and the doctors and the contractors, sometimes we have to work through some very difficult situations.

I will tell my colleagues that in talking with my doctors in the fifth district, one of the things that I heard over and over again was the sheer volume and complexity of the Medicare regulations and what it has meant to them. Most of what it means to them is they do not have the time to spend with their patients because they are spending so much time on the complexities.

Another issue that I think is very important about this is that these doctors also tell me, in talking with their staffs and their offices, that their administrative expenses can represent as much as 25 percent of their cost. That means, again, the cost to Medicare and the dollars that we have available is not being spent on the patient, but on administrative costs. So hiring an extra person, doing something more for the patient can sometimes cause a problem.

In seeing that in this piece of legislation, one of the things that we fought very hard for and I think is going to be a wonderful opportunity for us to look at in the future is the demonstration program that we provided to on-site technical assistance for doctors to help with the complexity of Medicare coding.

□ 1715

We heard an awful lot about that. So this was an issue we thought put them on site, they get the opportunity to really sit down with folks and figure out where their problems might be.

Then I also want to thank the gentleman from Minnesota (Mr. RAMSTAD) for his leadership on a piece of legislation that he and I introduced for a couple of years in a row dealing with technology. And so what we have done in this bill is we have actually set up a Council for Technology and Innovation within CMS. This council will have an executive coordinator who acts as a single point of contact between CMS and outside entities to help explain coverage, coding, and payment questions about new and innovative technologies.

We are all very proud of what happens in this country with innovation. So I would just like to take this opportunity to thank all, and our staffs, that were involved in this, and ask for my colleagues' support for this bill.

Mr. STARK. Mr. Speaker, I yield back the balance of my time.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I conclude by thanking the gentleman from California for his

cooperation throughout this long process, and our joint efforts, and also his staff, as I did earlier. They have worked very, very long hours on this.

And I would like to say that this bill is only the beginning of strengthening Medicare. The administration is organizing task forces with real-world providers on them to rethink the most time consuming forms that health care providers have to fill out. If we can collect only the data we need, streamline and simplify billing systems and administrative processes, we can literally free millions of hours of caregiver time for the benefit of our seniors. It will take the leadership of Secretary Thompson and Administrator Scully, and it will take long hearings and attention to detail next year and the year after, working together, our committee and the Committee on Energy and Commerce.

Together, we can make Medicare a model of smart, responsive government and reverse the belief expressed by so many in our hearings, but summed up by a doctor who said, ''Medicare has lost a sense of fairness, due process and common sense.'' We intend to restore those qualities to the most beloved and important program in our Nation not just for seniors but for their children and grandchildren as well.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume, and I rise today in strong support of H.R. 3391, the Medicare Regulatory Contracting Reform Act of 2001.

The bill captures the best of two bills. The legislation reported out of the Committee on Ways and Means, and H.R. 3046, the Medicare RACER Act, which was reported from the Committee on Energy and Commerce. It represents the diligent work of the many Members of Congress to make the Medicare program more flexible and less bureaucratic. It is also a shining example of what can be achieved when we have true bipartisan cooperation.

Earlier this year, the Committee on Energy and Commerce began a project we called ''patients first.'' The idea was indeed to try to see if we could not reform the regulations and the burdens at CMS to indeed put patients first; to make sure that physicians and health care providers, who are forced to spend too much time filling out forms and trying to learn the rules of the road and the changing rules of the road, might in fact get some relief.

Our committee held a number of hearings and we disseminated surveys to elicit input from beneficiaries and health care providers about the complexities of the Medicare program and its rules. We also brought together beneficiary groups, provider associations, and government officials to talk about regulatory relief.

Because of the leadership particularly of the gentleman from Pennsylvania (Mr. TOOMEY) and the gentlewoman from Nevada (Ms. BERKLEY), we are standing here today with an opportunity to vote on legislation that will enable doctors to spend more of their time caring for patients, putting patients first, and putting in less time completing paperwork for the government and bureaucrats.

The Toomey-Berkley Medicare RACER Act was successfully reported from the Subcommittee on Health, thanks to the dedication and commitment of the chairman, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Georgia (Mr. NORWOOD). It was also successfully reported out of the full Committee on Energy and Commerce. It requires contractors to provide general written responses to written inquiries from beneficiaries and health care providers within 45 business days, and it requires Medicare contractors to notify health care providers of problems that have been identified in a probe sample, and to alert providers as to the steps they should take to resolve the problems.

Each of these improvements is significant and each of them has been included in the bill we are about to vote on today. And I wish to thank my colleagues from the Committee on Ways and Means for working so well with the gentleman from Florida (Mr. BILIRAKIS), the gentleman from Ohio (Mr. BROWN), the gentleman from Michigan (Mr. DINGELL), and myself to consolidate the work of our two committees. Lord knows, we need to thank the staff who put in hours and hours and hours, late nights and weekends, to bring all this together.

We worked to strike an appropriate balance between the need for regulatory relief and the government's obligation to protect taxpayer funds from waste, fraud, and abuse. This captures the hard work of both committees. It has broad support with the beneficiary groups, the health care community and, by the way, the administration.

I urge my colleagues to join us in full support of the legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

I am pleased to join my colleagues both on the Committee on Ways and Means and the Committee on Energy and Commerce in support of H.R. 3391. I want to thank my colleagues, the gentleman from Pennsylvania (Mr. TOOMEY) and the gentlewoman from Nevada (Ms. BERKLEY) for taking on this daunting task. In a resource-limited environment, they were determined to identify reforms in Medicare operations that serve the best interests of beneficiaries and respond to a host of legitimate issues raised by providers, while making sure to in no way compromise the program's efforts to fight fraud, waste and abuse. It is a tall order and the gentleman from Pennsylvania and the gentlewoman from Nevada did an excellent job.

This bipartisan legislation was a collective effort, to say the least. It was written and rewritten and rewritten with the input of the health care community, consumer advocates, the committees of jurisdiction, and the administration. It took months, it took difficult compromises, but the final product will make a tangible, positive difference for beneficiaries and providers alike.

Key provisions of the bill bolster communications between and among the Medicare program and its beneficiaries and providers, improve the Medicare appeals process, and establish new performance standards for Medicare contractors.

No one is well served when providers either cannot get the information they need or coverage policies are unclear, or anti-fraud and abuse measures elicit such mistrust that providers second-guess every treatment decision. This legislation takes those issues seriously and does something about them. Importantly, the bill also provides and improves Medicare responsiveness to its 39 million beneficiaries.

I want to thank my colleagues, the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Florida (Mr. BILIRAKIS), and the gentleman from Michigan (Mr. DINGELL) especially, and staff members Bridgett Taylor, Karen Folk, Amy Hall, and on my staff, Katie Porter and Ellie Dehoney for fighting tooth and nail to ensure this legislation, in effect, keeps our eye on the ball. They made sure the bill contains provisions that relate directly to Medicare's fundamental mission, to make sure seniors and disabled individuals receive the care that they need.

Thanks largely to their resolve and hard work, this legislation ensures that seniors know definitively and up front whether Medicare covers the health care their doctor recommends. Especially for low-income seniors, that is a crucial and overdue change in Medicare rules, and I appreciate the negotiated work that we all could do on that issue.

The Medicare fee-for-service program is the largest insurance program in the United States, serving 36 million Americans, contracting with almost 1 million providers. Recent surveys document what most of us know from speaking with our constituents; that is, an overwhelming majority of Medicare beneficiaries trust in and are very satisfied with their coverage under fee-for-service Medicare.

Americans overwhelmingly oppose Republican efforts to privatize this system, Americans overwhelmingly reject Republican efforts to allow more insurance company intrusion into fee-for-service Medicare, and Americans overwhelmingly want prescription drug coverage, an area where this Congress and the Bush administration have so far failed miserably to achieve. But since that level of trust and satisfaction the people in this country have for Medicare is a fundamental measure of this program's success, changing the

Medicare rules was a high-stakes exercise that we, bipartisanly, were able to achieve.

I am confident that the changes encompassed in this bill are in the best interest of beneficiaries, most importantly; also to providers and taxpayers, and I encourage my colleagues to support it.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the distinguished chairman of the Subcommittee on Health of the Committee on Energy and Commerce.

Mr. BILIRAKIS. Mr. Speaker, I too rise today in support of patients. The legislation before us is good for patients. By reducing regulatory burdens and easing paperwork requirements, this legislation allows doctors to spend more of their time providing health care and less of their time wading through pages over rules and regulations.

At the beginning of this session, the Committee on Energy and Commerce launched an ambitious bipartisan initiative to reform the Centers for Medicare and Medicaid Services and to put patients first. This initiative became known as the ''patients first'' project. Much of the legislation before us today stems from the committee's work on this project, which was led by my colleague, the gentleman from Georgia (Mr. NORWOOD). Foundational to this work was the prior work of the gentleman from Pennsylvania (Mr. TOOMEY) and the gentlewoman from Nevada (Ms. BERKLEY).

The bill we will vote on today includes many of the provisions of the Medicare RACER Act, which was favorably reported out of my Subcommittee on Health as well as the full Committee on Energy and Commerce last month. It includes improvements focused on the Emergency Medical Treatment and Labor Act. Also included in the legislation is important language regarding advanced beneficiary notices. This language allows physicians to find out whether a specific physician service they are providing will be covered by Medicare before delivering the care.

Mr. Speaker, I would like to thank all of the staff who put so much time into this legislation, especially Erin Kuhls, Julie Corcoran, Nandan Kenkeremath, Pat Morriset, Anne Esposito, Steve Tilton, Karen Folk, Amy Hall, and, of course, last but not least, Karen Taylor.

H.R. 3391 is good for patients and providers alike, and I encourage my fellow colleagues to vote in favor of this legislation today.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. DINGELL), the ranking Democrat on the Committee on Energy and Commerce that was here and presided over this House when Medicare was passed in 1965.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Speaker, I thank my good friend for yielding me this time, and I rise today to speak in favor of H.R. 3391, the Medicare Regulatory and Contracting Reform Act of 2001. I rise also to praise my colleagues on the committee, the distinguished chairman of the committee, the distinguished chairman of the subcommittee, and my good friend, the gentleman from Ohio, Mr. BROWN and others, including the very fine staffs on both sides of the aisle that worked so hard.

The legislation is a product of bipartisan collaboration between two great committees, the Committee on Energy and Commerce and the Committee on Ways and Means, and also with seniors' groups, providers, and others. This is a bill which is fair. It strikes a balance between addressing the program administration concerns of beneficiaries and providers and ensuring integrity of the program itself.

This legislation makes a number of wise improvements in the Medicare program. It gives the Centers for Medicare and Medicaid Services, CMS, additional flexibility with claims processors. It also strengthens the independent standards for appeals. It entitles the beneficiaries and the reviewers to ensure independent appeals are really independent, are fair, and in fact take place.

I do wish again to commend my friend, the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Florida (Mr. BILIRAKIS), the staff at CMS, as well as my good friend the gentleman from Ohio, for their work on this, and also our friends on the Committee on Ways and Means and the majority and minority staff of both committees for the work they have done.

In addition to strengthening the requirements for organizations that will be reviewing appeals, we have improved upon notices that beneficiaries receive when a service is denied, making this situation more user friendly and understandable to beneficiaries who are most often in their later years. More importantly, we have developed a process where seniors can learn whether or not a particular item and service is covered under Medicare before they are financially committed to that service, something which is not presently the case and which creates immense hardship either by denying benefits or imposing unanticipated costs on senior citizens on fixed and limited incomes.

Currently the only way a senior can find out if Medicare covers an item or a service is to potentially risk thousands of his or her dollars by getting the service and then pray Medicare will pay the claim. Obviously, this is unfair, and many seniors choose not to get a service rather than take a chance that Medicare will not cover it. This legislation fixes this, a situation which is clearly unjust. And while the provision as it stands now is limited only to physician service in order to meet scoring requirements, I hope, and I intend that in the future we will give the beneficiaries this right for all Medicare services.

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Mr. Speaker, I urge my colleagues to support the bill. Medicare is the most socially successful and valuable program of this day. The program works for beneficiaries and providers alike, but we must ensure that it continues to be a success. The Medicare Regulatory and Contracting Reform Act will do just that.

More remains to be done, and I look forward to working with the same fine colleagues that I did to bring this about. The Medicare legislation that we have before us ensures that Medicare fee for services will continue to serve beneficiaries, and it will cause further approval and satisfaction with one of our great legislative accomplishments, Medicare.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. TOOMEY), the author of this legislation, who, together with the gentlewoman from Nevada (Ms. BERKLEY), put together 240 co-sponsors.

(Mr. TOOMEY asked and was given permission to revise and extend his remarks.)

Mr. TOOMEY. Mr. Speaker, I thank the gentleman from Louisiana (Mr. TAUZIN) for yielding me the time and also thank the gentleman for recognizing my efforts in the area of Medicare regulatory reform and for inviting me to join in with the Committee on Energy and Commerce in developing this terrific compromise legislation.

Since my first term in Congress, I have been working on Medicare regulatory reform to help alleviate some of the burdens that the health care providers carry when dealing with Medicare's bureaucracy. We need to give health care providers due process rights so they are not treated like criminals when they make honest mistakes. We need to make billing procedures easier for providers to understand and comply with and reduce the huge volume of paperwork that staff have to contend with.

This is important so health care providers can spend more time caring for their patients and less time dealing with bureaucracy. This bill addresses these problems. It is a step in the right direction, but it is a modest step. We need to do more. For instance, we need profound Medicare reform. As long as we have a Medicare bureaucracy that enumerates, regulates, and prices every conceivable medical procedure, we will continue to have enormous costs and inefficiencies in complying with these staggering regulations. But we cannot wait until we fully overhaul Medicare to provide the significant regulatory relief of this bill.

Mr. Speaker, I thank my colleagues who made this bill possible: the gentlewoman from Nevada (Ms. BERKLEY), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from California (Mr. STARK), the gentleman

from California (Chairman THOMAS), the gentleman from New York (Mr. RANGEL), the gentleman from Michigan (Mr. DINGELL), the gentleman from Florida (Mr. BILIRAKIS), and the gentleman from Ohio (Mr. BROWN).

I also thank some staff members, Gary Blank, formerly of my staff, Kelly Weiss, currently with my staff, and Pat Morrisey of the commerce staff, in particular.

Mr. Speaker, we take a big step forward today. I hope the same combination of the bipartisan group that worked on this bill can come back next year and do more work for health care providers and for their patients; but in the meantime, I urge my colleagues to pass H.R. 3391 and give the health care community some of the regulatory relief that they need and deserve.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I rise today in support of the Medicare Regulatory and Contracting Reform Act. The legislation makes a number of important changes to the way that Medicare does business, and it comes not a second too late.

For years we have been hearing from doctors and providers who complain that they are spending more time dealing with Medicare paperwork than they are treating patients. They express frustration where simple mistakes escalated into full-fledged investigations, where well-intentioned providers were penalized and accused of defrauding the system, and insufficient appeals process made it difficult for providers to make their case. Many are ready to stop treating Medicare patients altogether.

The Committee on Energy and Commerce passed legislation earlier this year that addresses many of these issues and would have made improvements in the Medicare system. Working with the Committee on Ways and Means, we were able to come up with a consensus bill that addressed the problem and makes the Medicare program more navigable for our Medicare providers. This legislation streamlines key Medicare processes so that providers are not trapped in a maze of confusing regulations.

It improves provider information and education so that doctors know who to call and what to do when they have trouble with a claim. The legislation also reforms the contracting system by giving the Secretary greater flexibility in selecting contractors, assigning contractor functions, and permitting competitive contracting.

There are many significant changes in the bill that will improve the Medicare system for providers and beneficiaries alike, and I support the legislation. I urge my colleagues to support this legislation.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I rise today in strong support of H.R. 3391. I commend it to all Members of this body, and I hope every Member will vote for this bill. No doubt the outcome of this vote will be noted by the body across the way, and it is important that we vote for something that is needed so badly.

Mr. Speaker, I thank the gentleman from Louisiana (Mr. TAUZIN) and the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Michigan (Mr. DINGELL) and the gentleman from Ohio (Mr. BROWN). And a great deal of credit and thanks should go to the Committee on Ways and Means, especially to the gentlewoman from Connecticut (Mrs. JOHNSON). On the commerce staff, I thank Pat Morrisey. He put up with a lot to get us here, and Erin Kuhls, Julie Corcoran, and Bridgett Taylor. They worked so hard to get us to where we are today.

Many Members have mentioned the good things that are in this bill. There are a lot of good things. I particularly would like to highlight the benefit that will be made available to patients for them to actually know if Medicare will cover a benefit that is a covered benefit. That is called preauthorization or predetermination, and probably in the end there is not much more in this bill that will be more important to the quality of care for Medicare patients to actually get treated.

But I note, as the gentlewoman from Connecticut (Mrs. JOHNSON) has said, that this is a first step. I hope we will all recognize that, and I would like to have a colloquy with the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. BILIRAKIS); and I will ask both the question at the same time.

Although many good things have been done in this bill, this is a first step and I want to be part of working these two committees together next year and I would like to hear from both Members. Can we plan to move forward next year?

Mrs. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. NORWOOD. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I can guarantee the gentleman that we will work together next year. We learned a lot this year. We solved some problems that we can understand. We laid aside what we could not understand. There is lots more work to be done to make Medicare a smart and efficient program.

Mr. BILIRAKIS. Mr. Speaker, will the gentleman yield?

Mr. NORWOOD. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Speaker, as the gentleman knows because he was in the room last week, I put my life on the line in terms of a question that was asked, and the gentleman from Louisiana (Chairman TAUZIN) did, too; not the chairman's life, my life, on the line.

I will not go quite that far this time around, but I feel very strongly that this is a first step. There is a tremendous amount of work to be done.

Mr. BROWN of Ohio. Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, there is a provision that many have spoken of already that actually was something that I brought up and proved to be one of the more difficult things to work out between the two committees and that was on the predetermination of benefits.

As a physician in the earlier 1990s when I was taking care of Medicare patients, sometimes we would do a procedure where it might or might not be considered medically necessary by Medicare. All that we wanted was to know whether Medicare would cover this or not. So at that time the data could be gathered together, send in the physical exam and tests, and Medicare would give their opinion. Then they stopped doing that. I think it scared a lot of patients from not having medically necessary procedures.

Mr. Speaker, that has been worked out in this bill. I thank the members of both committees and both parties for working on this. I think this will be a big improvement for patients.

Mr. TAUZIN. Mr. Speaker, I yield such time as he may consume to the gentleman from Indiana (Mr. BUYER).

Mr. BUYER. Mr. Speaker, I rise in support of the Medicare Regulatory and Contracting Reform Act. I would like to express my appreciation to the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Florida (Mr. BILIRAKIS), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Michigan (Mr. DINGELL), and the gentleman from Ohio (Mr. BROWN) for their assistance in working on the concern of dentists who often file Medicare claims even though the dental services are not covered by Medicare.

The provision in the bill seeks to help reduce the paperwork burden on dentists and expedite payment for services from appropriate sources of that payment. In addition, I am grateful that language can be worked out that will assist the medical device manufacturing community, enhancing the communications and cooperation between the Food and Drug Administration and the Centers for Medicare and Medicaid Services. This is an excellent bill, and I urge its passage.

Mr. CRANE. Mr. Speaker, I rise today in support of the Medicare Regulatory and Contracting Reform Act of 2001. This bipartisan legislation is the product of months of negotiations with the Center for Medicare and Medicaid Services (CMS), Medicare providers, beneficiaries, and the House Committees on Ways and Means and Energy and Commerce.

This legislation is a first step in ensuring that the Medicare program delivers quality care to Medicare beneficiaries. Today, the

Medicare program has more that 110,000 pages of regulations governing it. This bill begins to finally address how to hold CMS accountable for its regulations and the costs they impose.

The Medicare Regulatory and Contracting Reform Act creates a more collaborative, less confrontational relationship between providers and CMS. It takes steps to decrease the amount of complex and technical paperwork that is currently required so that providers will be able to spend more time delivering care to patients rather than filling out and filing federal forms. Finally, H.R. 3391 streamlines the regulatory process, enhances education and technical assistance for Medicare providers.

I was also pleased to see inclusion of a provision to prohibit group health plans from requiring a Medicare claims determination for dental benefits that are specifically excluded from Medicare coverage as a condition of making a determination for coverage under the group health plan. This requirement to me does not serve any purpose other than the filing of needless paperwork and further delay payment to the dental provider. This provision ensures that dentists do not have to submit claims to the Medicare program (and thus enroll in the Medicare program) when the services they are providing are clearly those that are categorically excluded from coverage.

I urge my colleagues to join me in support of this legislation.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of H.R. 3391, the Medicare Regulatory and Contracting Reform Act. As a physician in private practice for more than 20 years, I wholeheartedly applaud the work of the Ways and Means Committee and the Energy and Commerce Committee in moving legislation which lifts many of the burdens placed on physicians by the Medicare program and allow us to put our patients first.

Mr. Speaker, I can't tell you the number of times over the four and a half years that I have been a member of this body that I have heard horror stories from providers in my district regarding the cumbersome and burdensome Medicare billing process. They only serve to remind me of my personal experience in over 21 years of practice. Whether it is undue delays in receiving payments or repeatedly questioning information that was already provided, the current Medicare system treats physicians as suspects and requires that we spend nearly half of our time on needless paper work. It further makes hard working providers the first targets for fee reductions, repudiating their long years of training and hard work.

I applaud the authors of this legislation, Congresswoman NANCY JOHNSON and PETE STARK of the Ways and Means Committee, as well as Representatives BILIRAKIS, SHERROD BROWN, BILLY TAUZIN and my friend JOHN DINGELL for their support of doctors and the patients that they serve. Indeed, Mr. Speaker, no less than the General Accounting Office documented the statements that I can personally attest to regarding the difficulties of dealing with the Medicare program, pointing out that Medicare is a complicated program requiring endless directives and long explanations and articles which are necessary to explain facet after facet.

I urge my colleagues to support this badly needed bill which is but a first step in addressing what are myriad problems with this important health insurance program.

Mr. SHADEGG. Mr. Speaker, I rise today to support the Medicare Regulatory and Contracting Reform Act. Since I have been in Congress, I have constantly heard from hospitals and physicians about the guessing game they must play in order to be compliant with Medicare regulations. The paperwork that providers must complete both for private insurance and for Medicare is overwhelming them. Where twenty years ago, it was uncommon to have more than one administrative person working in a physician's office, today it seems to be the norm to have multiple employees handling claims. Like a punch-drunk fighter, our nation's health care providers are dizzy from the barrage of notices, guidance, and issuances from Medicare describing ever-changing policies and regulations. Worse yet, many of these providers approach the billing process with trepidation. Fearful that they may be audited or have payments withheld, many physicians downcode so as to reduce their potential exposure even though they legitimately deserve reimbursement for a higher code. Moreover, a simple, honest mistake, providers fear, will result in harsh penalties and send them into a regulatory spiral, thus taking them away from their patients. This is one of the reasons I was a cosponsor of the Medicare Education and Regulatory Fairness Act and support the bill on the floor today. H.R. 3391 provides important reforms of the Medicare system to streamline Medicare's regulatory process, ease paperwork burdens, and improve Medicare's responsiveness to beneficiaries and health care providers.

I am particularly pleased that H.R. 3391 includes provisions aimed at improving the functioning of the Emergency Medical Treatment and Active Labor Act, better known as EMTALA. While a well-intended provision to ensure that patients coming to hospital emergency departments are not shipped from hospital to hospital or ''dumped,'' EMTALA is now serving as an impediment to hospital emergency department access, the exact opposite of what the original legislation was intended to do. The provisions I included at the Full Committee markup include recreating the EMTALA task force, something suggested not only in the January 2001 Inspector General's report, but also in the June 2001 GAO report. Physicians and providers are crying out for clarification and guidance on how to comply with the myriad, confusing EMTALA regulations and this task force will be charged to work synergistically to make the regulations manageable. In addition, the bill on the floor today implements another suggestion from the Inspector General, mandatory peer review organization. Under current law, a peer review organization must review any EMTALA deficiency or violation involving medical treatment before a civil monetary penalty can be levied, but the same does not apply to those providers facing removal from the Medicare program. The Medicare Regulatory and Contracting Reform Act will restore equity by requiring PRO review in the Medicare conditions of participation. Last, the bill will require the Centers for Medicare and Medicaid Services to notify providers directly when an EMTALA investigation is closed.

Mr. Speaker, these are important provisions to address a complex situation—emergency department overcrowding—and I thank Chairman TAUZIN for working with me in Committee as well as members of the Ways and Means Committee as we merged the two committee bills.

Mr. UPTON. Mr. Speaker, on behalf of all of the physicians and other health professionals in my District who provide care to Medicare beneficiaries and on behalf of the beneficiaries themselves, I rise to express my strong support for H.R. 3391, the Medicare Regulatory and Contracting Reform Act of 2001. I am honored to be an original cosponsor of this bipartisan, common-sense bill that will provide much-needed regulatory relief and greater program fairness, clarity, and transparency.

From what I have been hearing for years now in my meetings with Medicare beneficiaries and health care providers across my District, the current program is simply not working well. Beneficiaries and health professionals often don't know if services will be covered, leading some beneficiaries to forgo needed care. It can take months—and mounds of paperwork—just to get paid for health care services. I've seen the inch-thick paperwork that can be required just to document one claim.

Doctors and other health professionals feel that they are practicing with a sword over their heads. The rules and regulations are so complex that the Medicare intermediaries and carriers all too often give conflicting advice and guidance. Regulations and guidance change so frequently that it is difficult to know what the rules are at any one time, and what they will be tomorrow. Making a simple mistake in coding or misunderstanding a program requirement, health professionals fear, could well open to a fraud charge. If a claim is denied, it can take several years to go through the current process for appealing that denial. Doctors are so frustrated with the program that they are retiring early, and some beneficiaries are having a hard time finding doctors willing to take them as patients once they turn 65.

The Medicare Regulatory and Contracting Reform Act will give the Centers for Medicare and Medicaid Services the direction and flexibility needed to streamline the regulatory and contracting processes. It will provide strong incentives for intermediaries and carriers to be responsive to beneficiaries and health professionals. It will provide additional resources for provider education. One provision that could be particularly helpful for both beneficiaries and providers will test the effectiveness of placing Medicare experts in local Social Security offices so that questions and concerns can be addressed in a timely, accurate way. And when disputes do arise, Administrative Law Judges specifically trained in Medicare law and regulation will hear the cases.

These are just a few of the reforms in this comprehensive, much-needed bill.

Mr. BENTSEN. Mr. Speaker, I rise today in strong support of the Medicare Regulatory and Contracting Reform Act (H.R. 3391), legislation which would reform our Medicare regulatory and contracting system. For too long, Medicare providers have encountered problems in resolving claims under the Medicare program. Today, many Medicare providers submit claims to their Medicare contractor who do not provide timely resolution for these claims. In addition, many Medicare providers face lengthy appeals which result in delayed reimbursements. This legislation would not only provide necessary regulatory relief to Medicare providers, but it would also ensure

that Medicare contracts are competitively bid so that taxpayers are paying the lowest price for these services.

In order to help with better compliance by Medicare providers, this legislation would require that Medicare regulations should be promulgated only once a month. This bill requires the Department of Health and Human Services (HHS) to develop time lines for Center for Medicare and Medicaid Services (CMS) rules. As a result, Medicare providers would know when to expect changes in the Medicare system and would be able to plan for such changes. This measure prohibits regulations from being applied retroactively and requires that any substantive change in regulations from being applied retroactively and requires that any substantive change in regulations should not become effective until 30 days after the change has been announced. The bill also protects providers by ensuring that they cannot be sanctioned if they followed written guidance provide by HHS or by a contractor. Providers would also be eligible to call a new Medicare Ombudsman to assist Medicare providers with advice about Medicare regulations and rules.

To ensure that contractors are more accountable to Medicare providers, this bill encourages HHS to competitively bid contracts for Medicare claims. This new procedure would eliminate the current system where health care providers can nominate entities to become Medicare contractors. We should eliminate this conflict of interest and would ensure that taxpayers receive the best value for this program.

This bill allows providers to seek a hardship designation if they have received overpayments. Under this program, Medicare providers and suppliers could request to make repayments over a period of six months to three years if their obligation exceeds 10 percent of their annual payments from Medicare. In extreme circumstances, Medicare providers could apply for a five-year repayment schedule. Many medical small businesses which depend on Medicare for payments have requested this flexibility so that they continue to provide services to Medicare beneficiaries.

This measure also includes several provisions related to physician payment fees. Under current law, these Medicare physician fees will be reduced by 5.9 percent effective January 1, 2001. For many physicians, this significant drop in Medicare payments will impose a financial burden and may result in fewer physicians being willing to participate in this program. This bill requires the General Accounting Office (GAO) to report of Congress on the conversion factor used to calculate physician payments and to make recommendations on how to reform it within 12 months. This GAO report would also examine whether the current sustainable growth formula for physician fees should be reformed I have been contacted by many physicians in my district who would be adversely impacted by this new fee schedule and I am committed to working to change these payments in a timely manner so that Medicare payments more accurately reflect the true cost of providing care for Medicare patients.

As the representative for the Texas Medical Center, where many Medicare providers work, I urge my colleagues to support H.R. 3391 that will reform the Medicare program.

Mr. CARDIN. Mr. Speaker, I rise today in strong support of the Medicare Regulatory and Contracting Reform Act of 2001. This bill is the result of months of collaborative efforts between Democrats and Republicans, between the ways and means and the Energy and Commerce Committees. In other words, it was developed the way that responsible Medicare legislation should be-in a bipartisan and deliberative manner.

For too long, Congress has ignored the valid concerns of one of Medicare's most important assets—its health care providers. By easing regulatory burdens on physicians and allied health professionals, and by modifying the provider appeals process, this legislation speaks to some of the foremost concerns that have been brought to Congress by the dedicated health care professionals who participate in the Medicare program.

This bill also provides important patient protections for beneficiaries—it guarantees them access to a truly independent external review process; it improves the advance beneficiary notice (ABN) process so that seniors may know in advance of receiving care whether the services will be reimbursed by Medicare; and it establishes a Beneficiary Ombudsman to assist seniors in navigating the Medicare program.

As the Medicare+Choice program enters its fifth year, and enrollees across the country are witnessing their benefits reduced and their premiums increased, this bill contains an important beneficiary protection. It delays by one year the implementation of the enrollee ''lock-in'' period, which will enable many seniors to move between HMOs as efforts are made to stabilize this program.

The 1997 Balanced Budget Act imposed $1500 caps on physical, speech-language, and occupational therapy. I have long supported replacing these caps with a rational payment mechanism. Congress has acted each year to delay these caps, which discriminate against the most frail beneficiaries. However, it is a waste of energy and resources for providers to return to Congress annually to seek a one-year moratorium on these caps. Medicare should implement a rational payment system that provides seniors with the level of care they need. We passed a law requiring the Secretary of Health and Human Services to establish a mechanism for assuring appropriate use of services and to study use of these services by last June. This bill directs the Secretary to produce these overdue reports so that Congress can enact sound reimbursement policy for outpatient therapy.

Mr. Speaker, H.R. 3391 is a shining example of how Congress can act to greatly improve the Medicare program for beneficiaries and providers. I am pleased to be an original cosponsor of this legislation and I urge my colleagues to support it this evening.

Mr. ENGLISH. Mr. Speaker, I rise in strong support of H.R. 3391, The Medicare Regulatory Reform Act of 2001. I urge my colleagues to vote in favor of this important legislation.

The Occupational Safety and Health Administration (OSHA) estimates that each year 5.6 million workers in the health care industry are exposed to blood-borne diseases because of needlesticks. OSHA studies have shown that nurses sustain the majority of these injuries and that as many as one-third of all sharps injuries have been reported to be related to the disposal process.

In addition, the Centers for Disease Control estimates that 62 to 88 percent of sharps injuries can potentially be prevented by the use of safer medical devices. However, needlestick injuries and other sharps-related injuries, that result in occupational blood-borne pathogens exposure, continue to be an important public health concern.

H.R. 3391, The Medicare Regulatory Reform Act of 2001, includes a provision that will reduce needlestick injuries. This provision requires public hospitals, not otherwise covered by the OSHA rules, to meet the administration's standards which require employers to implement the use of safety-designed needles and sharps. The requirements will be established under Medicare statute and enforced through monetary fines similar to fines under OSHA. Violations would not cause hospitals to lose Medicare their eligibility.

I also would like to take this opportunity to thank Subcommittee Chairwoman NANCY JOHNSON for not only including this provision to reduce needlestick injuries in the Medicare regulatory reform bill, but also for her many years of hard work on this issue. She has long been a champion of requiring public hospitals to use safety-designed needles and sharps. I was pleased to join her and Mr. STARK in this important effort.

We have the technology to provide better protections for our healthcare workers. A vote in favor of this legislation ensures that hospitals are using state-of-the-art equipment while significantly reducing the risk to healthcare workers.

Mr. KLECZKA. Mr. Speaker, I am pleased that the House of Representatives is considering the Medicare Regulatory and Contractor Reform Act of 2001 (H.R. 3391) on the suspension calendar today.

This important, bipartisan legislation will address the very real and practical regulatory concerns health care providers, contractors, and beneficiaries are currently facing with the Medicare program. H.R. 3391 helps providers and beneficiaries better understand the complexities of Medicare, while at the same time protecting the Federal Claims Act and maintaining strong efforts to eliminate waste, fraud and abuse. It is my hope that this legislation will allow providers to focus their attention on patients, and not bureaucracy.

Of particular importance to me was the inclusion of language I offered during the Ways and Means Health Subcommittee markup that would establish a new Medicare Beneficiary Ombudsman. H.R. 2768, as originally introduced by the Ways and Means Committee, had included language requiring the U.S. Department of Health and Human Services (HHS) Secretary to appoint a Medicare Provider Ombudsman to provide confidential assistance to physicians and practitioners regarding complaints and grievances. I believed this point-of-contact should be extended to Medicare beneficiaries, who also have complex questions and receive conflicting guidance. I am pleased that my suggestion to create a comparable Beneficiary Ombudsman to serve as a voice for beneficiaries within the Centers of Medicare and Medicaid Services (CMS) was included. This provision should enable the Agency to better anticipate and address beneficiary needs.

Furthermore, I requested language in Title II of the Act that would eliminate the provider

nomination provisions for contracting purposes. This provision effectively waives the prime contracts that the Centers of Medicare and Medicaid Services (CMS) currently has with national organizations and permits CMS to contract directly with entities during the transition period prior to the October 1, 2003 effective date without regard to competitive bidding procedures.

I would like to express my sincere appreciation to both Ways and Means Health Subcommittee Chairwoman JOHNSON and Ranking Member STARK, and their respective staffs, for being so accommodating and working together to create responsible, well-targeted regulatory legislation.

I urge my colleagues to support H.R. 3391, and I hope the Senate will work quickly to pass this legislation prior to the end of this Congressional Session.

Mr. BROWN of Ohio. Mr. Speaker, I yield back the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentlewoman from Connecticut (Mrs. JOHNSON) that the House suspend the rules and pass the bill, H.R. 3391.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. TAUZIN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

AMENDING INTERNAL REVENUE CODE TO SIMPLIFY REPORTING REQUIREMENTS

Mr. HULSHOF. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3346) to amend the Internal Revenue Code of 1986 to simplify the reporting requirements relating to higher education tuition and related expenses.

The Clerk read as follows:

H.R. 3346

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SIMPLIFICATION OF REPORTING REQUIREMENTS RELATING TO HIGHER EDUCATION TUITION AND RELATED EXPENSES.

(a) AMENDMENT RELATING TO PERSONS REQUIRED TO MAKE RETURN.—Paragraph (1) of section 6050S(a) of the Internal Revenue Code of 1986 (relating to returns relating to higher education tuition and related expenses) is amended to read as follows:

''(1) which is an eligible educational institution which enrolls any individual for any academic period;''.

(b) AMENDMENTS RELATING TO FORM AND MANNER OF RETURNS.—Subsection (b) of section 6050S of such Code is amended as follows:

(1) Paragraph (1) is amended by inserting ''and'' after the comma at the end.

(2) Subparagraph (A) of paragraph (2) is amended to read as follows:

''(A) the name, address, and TIN of any individual—

''(i) who is or has been enrolled at the institution and with respect to whom transactions described in subparagraph (B) are made during the calendar year, or

''(ii) with respect to whom payments described in subsection (a)(2) or (a)(3) were made or received,''.

(3) Paragraph (2) of section 6050S(b) of such Code is amended by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(4) Subparagraph (B) of section 6050S(b)(2) of such Code, as redesignated by paragraph (3), is amended to read as follows:

''(B) the—

''(i) aggregate amount of payments received or the aggregate amount billed for qualified tuition and related expenses with respect to the individual described in subparagraph (A) during the calendar year,

''(ii) aggregate amount of grants received by such individual for payment of costs of attendance that are administered and processed by the institution during such calendar year,

''(iii) amount of any adjustments to the aggregate amounts reported by the institution pursuant to clause (i) or (ii) with respect to such individual for a prior calendar year,

''(iv) aggregate amount of reimbursements or refunds (or similar amounts) paid to such individual during the calendar year by a person engaged in a trade or business described in subsection (a)(2), and

''(v) aggregate amount of interest received for the calendar year from such individual, and''.

(c) CONFORMING AMENDMENTS.—Subsection (d) of section 6050S of such Code is amended—

(1) by striking ''or (B)'', and

(2) in paragraph (2), by striking ''subparagraph (C)'' and inserting ''subparagraph (B)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses paid or assessed after December 31, 2002 (in taxable years ending after such date), for education furnished in academic periods beginning after such date.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Missouri (Mr. HULSHOF) and the gentleman from Maryland (Mr. CARDIN) each will control 20 minutes.

The Chair recognizes the gentleman from Missouri (Mr. HULSHOF).

GENERAL LEAVE

Mr. HULSHOF. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 3346.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Missouri?

There was no objection.

Mr. HULSHOF. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, education is the great equalizer, and getting a college education remains a part of the American dream. Yet affording that education at an institution of higher learning can be a nightmare for a prospective student or that student's family.

According to a 1997 GAO report, since the early 1980s college tuition has increased by 234 percent, which of course far outpaces the cost of living or any rise in family income. Some students balance their class work with part-time jobs, others rely on financial aid packages or scholarships. This body, Mr. Speaker, has attempted in the past to ease the financial burden. Back in 1997 Congress passed and former President Clinton signed into law the Taxpayer Relief Act of 1997. This legislation created the Hope Tax Credit as well as the Lifetime Learning Tax Credit to help families afford the cost of sending a child to college.

Since then we have built on our work. We have added to the success of the 1997 bill. We have expanded education savings account. We have made prepaid tuition plans more attractive, and we have expanded the student loan interest deduction.

When the merits of the Hope Credit and the Lifetime Learning Credit were being considered back in 1997, the potential compliance costs for colleges and universities were raised as a potential drawback. In fact, I recall and probably the gentleman from Maryland (Mr. CARDIN) may recall the particular hearing we had in front of the Committee on Ways and Means and the former Treasury Secretary was appearing before us, and I asked Mr. Rubin about the compliance cost. We had been alerted to some potential substantial administrative burdens that colleges and universities were going to have to undertake, even while implementing this worthwhile legislation. I recall the answer that Mr. Rubin gave; he felt it would be a small, insignificant cost.

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In fact, I think he said it would be the cost of a pencil and a piece of paper. Well, as C-SPAN was covering that hearing live that day, the phone lines in our congressional office began to light up as school administrators from around the country began to call, again with this concern about this burden, this compliance cost that they would have to undertake if, in fact, we enacted the HOPE scholarship or the HOPE tax credit, as well as the lifetime learning credit and, unfortunately, their premonition has been borne out. It has been clear that our Nation's institutions of higher learning have faced significant increased administrative burdens, which brings us today.

The bill before us, H.R. 3346 that has been introduced by the gentleman from Illinois (Mr. MANZULLO), accomplishes the goal of reducing administrative burdens on schools, while retaining the integrity of the HOPE and lifetime learning credits. We accomplish this by modifying how tuition amounts are reported and also eliminating an unneeded reporting requirement in current law that colleges and universities provide the Internal Revenue Service with the name, address, and taxpayer identification number of taxpayers who could claim students attending the school as dependents. While these